

Idaho

UNOFFICIAL DEATH CERTIFICATE ABSTRACT

THIS ABSTRACT IS NOT AN OFFICIAL IDAHO CERTIFICATE OF DEATH AND
SHALL NOT BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH

DECEDENT	TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN	FOR INSTRUCTIONS SEE HANDBOOKS	MORTICIAN: Complete/Verify and File Within 5 Days of Death	★ 1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)				2. SEX		3. SOCIAL SECURITY NUMBER			
				4a. AGE-Last Birthday (Years)		4b. UNDER 1 YEAR MonthsDays		4c. UNDER 1 DAY HoursMinutes		5. DATE OF BIRTH (Mo/Day/Yr)		6. BIRTHPLACE (City and State, Territory, or Foreign Country)	
				7a. RESIDENCE - STATE OR FOREIGN COUNTRY				7b. COUNTY		7c. CITY OR TOWN			
				7d. STREET AND NUMBER				7e. APT. NO.		7f. ZIP CODE		7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Unknown						9. SURVIVING SPOUSE'S NAME (If wife, give maiden name)			
PARENTS				10. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		11a. FATHER'S NAME (First, Middle, Last, Suffix)				11b. BIRTHPLACE (State, Territory, or Foreign Country)			
				12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)				12b. BIRTHPLACE (State, Territory, or Foreign Country)					
INFORMANT				13a. INFORMANT'S NAME (Type or print)		13b. RELATIONSHIP TO DECEDENT		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)					
DISPOSITION				★ 14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify) _____		15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)		★ 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY					
PLACE OF DEATH				★ 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶		★ 17b. LICENSE NUMBER (Of licensee)		18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
				PLACE OF DEATH (19-22) ★ 19a. IF DEATH OCCURRED IN A HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Hospice facility 5 <input type="checkbox"/> Nursing home/Long term care facility 6 <input type="checkbox"/> Decedent's home 7 <input type="checkbox"/> Other (Specify) _____ ★ 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ★ 20. FACILITY NAME (If not facility, give street and number) ★ 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE ★ 22. COUNTY OF DEATH									
DATE OF DEATH				★ 23. DATE OF DEATH (Mo/Day/Yr) (Spell month)		24. TIME OF DEATH (24hr)		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month)		26. TIME PRONOUNCED DEAD (24hr)			
CAUSE OF DEATH				27. CAUSE OF DEATH PART I. Enter the chain of events-- diseases, injuries, or complications -- that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line: IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ DUE TO (or as a consequence of): _____ Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death) b. _____ DUE TO (or as a consequence of): _____ c. _____ DUE TO (or as a consequence of): _____ d. _____ PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I 28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No 28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No 31. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined									
ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)				29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		30. IF FEMALE (Aged 10-54): <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death		31. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined					
				32. DATE OF INJURY (Mo/Day/Yr) (Spell month)		33. TIME OF INJURY (24hr)		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)		35. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				36. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____ Apartment Number _____									
CERTIFIER	IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE			37. DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable									
				TRANSPORTATION INJURY ONLY		38a. WAS DECEDENT: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		38b. WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? <input type="checkbox"/> Seat Belt <input type="checkbox"/> Child safety seat <input type="checkbox"/> Helmet <input type="checkbox"/> Air bag <input type="checkbox"/> None <input type="checkbox"/> Unknown					
REGISTRAR				39a. CERTIFIER (Check only one, based on official capacity for this certificate) <input type="checkbox"/> PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the <u>natural</u> cause(s)/manner stated. <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> CORONER - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. Signature and Title of Certifier ▶ ★ 39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)						39b. LICENSE NUMBER			
										39c. DATE SIGNED ____/____/____ MM DD YYYY			
				40a. REGISTRAR'S SIGNATURE ▶						40b. DATE SIGNED ____/____/____ MM DD YYYY			

STATISTICAL INFORMATION

MORTICIAN: Complete/Verify	41. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life) <i>Do not use retired</i>		45. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)			
	42. KIND OF BUSINESS/INDUSTRY		01 <input type="checkbox"/> White		10 <input type="checkbox"/> Other Asian (Specify) _____	
	43. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death) 1 <input type="checkbox"/> 8th grade or less (includes none) 2 <input type="checkbox"/> 9th - 12th grade, but no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (eg, AA, AS) 6 <input type="checkbox"/> Bachelor's degree (eg, AB, BA, BS) 7 <input type="checkbox"/> Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW) 8 <input type="checkbox"/> Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)		02 <input type="checkbox"/> Black or African American		11 <input type="checkbox"/> Native Hawaiian	
	44. DECEDENT OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino) 0 <input type="checkbox"/> No, not Spanish/Hispanic/Latino 1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano 2 <input type="checkbox"/> Yes, Puerto Rican 3 <input type="checkbox"/> Yes, Cuban 4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		03 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____		12 <input type="checkbox"/> Guamanian or Chamorro	
			04 <input type="checkbox"/> Asian Indian		13 <input type="checkbox"/> Samoan	
			05 <input type="checkbox"/> Chinese		14 <input type="checkbox"/> Other Pacific Islander (Specify) _____	
			06 <input type="checkbox"/> Filipino		15 <input type="checkbox"/> Other (Specify) _____	
			07 <input type="checkbox"/> Japanese			
			08 <input type="checkbox"/> Korean			
			09 <input type="checkbox"/> Vietnamese			

* At a minimum, complete items 1; 14; 16; 17a; 17b; 19a or 19b; 20; 21; 22; 23; and 39d for the 24-Hour Report and Authorization for Final Disposition